31A-17-101. Scope.

Except as otherwise provided under this code, this chapter and the rules adopted to implement it apply to all insurers, including reinsurers, authorized to do business in this state.

Enacted by Chapter 242, 1985 General Session

31A-17-102. Standards for accounting rules.

When adopting accounting rules, the commissioner shall consider recommendations made by the National Association of Insurance Commissioners. Accounting rules shall follow generally accepted accounting principles, except as modified by statutory insurance accounting principles.

Enacted by Chapter 242, 1985 General Session

31A-17-201. Qualified assets.

(1) Except as provided under Subsections (3) and (4), only the qualified assets listed in Subsection (2) may be used in determining the financial condition of an insurer, except to the extent an insurer has shown to the commissioner that the insurer has excess surplus, as defined in Section 31A-1-301.

(2) For purposes of Subsection (1), "qualified assets" means:

(a) any of the following acquired or held in accordance with Sections 31A-18-105 and 31A-18-106:

(i) an investment;

(ii) a security;

(iii) property; or

(iv) a loan;

(b) the income due and accrued on an asset listed in Subsection (2)(a);

(c) assets other than an asset listed in Subsection (2)(a) that are determined to be admitted in the Accounting Practices and Procedures Manual, published by the National Association of Insurance Commissioners; and

(d) other assets authorized by the commissioner by rule.

(3) (a) Subject to Subsection (5) and even if the assets could not otherwise be counted under this chapter, assets acquired in the bona fide enforcement of creditors' rights may be counted for the purposes of Subsection (1) and Sections 31A-18-105 and 31A-18-106:

(i) for five years after the acquisition of the assets if the assets are real property; and

(ii) for one year if the assets are not real property.

(b) (i) The commissioner may allow reasonable extensions of the periods described in Subsection (3)(a), if disposal of the assets within the periods given is not possible without substantial loss.

(ii) Extensions under Subsection (3)(b)(i) may not, as to any particular asset, exceed a total of five years.

(4) Subject to Subsection (5), and even though under this chapter the assets could not otherwise be counted, assets acquired in connection with mergers,

consolidations, or bulk reinsurance, or as a dividend or distribution of assets, may be counted for the same purposes, in the same manner, and for the same periods as assets acquired under Subsection (3).

(5) Assets described under Subsection (3) or (4) may not be counted for the purposes of Subsection (1), except to the extent they are counted as assets in determining insurer solvency under the laws of the state of domicile of the creditor or acquired insurer.

Amended by Chapter 252, 2003 General Session

31A-17-202. Status of assets that are not "qualified assets."

(1) (a) Except as provided in Subsection (1)(b), if an insurer owns assets that are not qualified assets under Section 31A-17-201, the assets shall be disregarded in determining and reporting the financial condition of the insurer.

(b) An insurer may invest its funds in investments that are permitted under Section 31A-18-105 but in excess of the limits under Sections 31A-18-103 and 31A-18-106 or other assets approved by the commissioner and these assets may be recognized and reported in the financial condition of the insurer to the extent the insurer has excess surplus, as defined under Section 31A-1-301.

(2) Insurers bear the burden of establishing the extent to which they have excess surplus.

Amended by Chapter 131, 1999 General Session

31A-17-203. Encumbering of assets.

(1) No domestic insurer may pledge, hypothecate, or otherwise encumber its assets to secure the debt, guaranty, or obligation of any other person. This prohibition does not apply to obligations of the insurer under surety bonds or insurance contracts issued in the regular course of business.

(2) No domestic insurer may pledge, hypothecate, or otherwise encumber its assets in an amount in excess of the amount of its capital and surplus, without the prior written consent of the commissioner.

(3) The commissioner may grant a domestic insurer an exception to Subsection (2) for a reinsurance agreement which may cause assets of the domestic insurer to be held, deposited, pledged, hypothecated, or otherwise encumbered in an amount in excess of capital and surplus to secure, offset, protect, or meet reserves or liabilities of the insurer that are established, incurred, or required under the provisions of the reinsurance agreement. The domestic insurer shall first file with the commissioner a written request for this exception, accompanied by a copy of the proposed reinsurance agreement and specifically stating its purpose and the reasons the exception should be granted.

(4) Any person that accepts a pledge, hypothecation, or encumbrance of any asset of an insurer not in accordance with the terms and limitations of this section is considered to have accepted that asset subject to a superior, preferential, and perfected lien in favor of owners, beneficiaries, assignees, certificate holders, or third party claimants or beneficiaries of any insurance benefit or right arising out of and within

the coverage of any insurance policy issued by the insurer. The commissioner may bring or participate in an action in any court of competent jurisdiction to protect the interests of insureds or claimants under this section.

Enacted by Chapter 204, 1986 General Session

31A-17-401. Valuation of assets.

(1) The commissioner shall value the assets of insurers in accordance with then current insurance business practices, but not in a manner inconsistent with the provisions of this title. In valuing assets, the commissioner shall consider any method then current, formulated, or approved by the National Association of Insurance Commissioners.

(2) Assets that are not qualified assets under Subsection 31A-17-201(2) are considered to have no value in evaluating an insurer's compliance with Chapter 17, Part 6, Risk-Based Capital. Those assets may be used in evaluating the insurer's financial condition only to the extent the insurer has excess surplus.

(3) (a) Insurance subsidiaries are valued on the books of a parent insurer as follows:

(i) Except as provided under Subsections (3)(a)(iii) and (iv), common stock of the subsidiary is valued on the basis of the parent insurer's percentage of ownership of the common stock multiplied by the total of the subsidiary's capital and surplus, less amounts needed to liquidate all claims to the capital and surplus which are senior to common stock. Subsection 31A-18-106(1)(k) provides applicable limitations on investments in subsidiaries.

(ii) The value of securities other than common stock issued by a subsidiary is the lesser of the present value of the future income to be derived under the securities or the amount the parent insurer would receive as a result of the securities if the subsidiary were liquidated and all creditors of the subsidiary and holders of the subsidiary's securities with senior priority were paid in full. The present value of future income derived from securities is determined by rule adopted by the commissioner. A parent insurer may attribute value to a security of its subsidiary only if the parent insurer is being paid dividends or interest on the security, and only if the parent insurer can reasonably anticipate that dividends or interest will continue to be paid on the security.

(iii) Except as provided under Subsection (3)(a)(iv), any portion of the subsidiary's value permitted under Subsection (3)(a) that is represented by assets other than assets listed under Section 31A-17-201, may only be classified as excess surplus of the parent insurer, and then only to the extent the parent insurer has established that it has excess surplus under Section 31A-17-202.

(iv) For the purposes of Subsection (3)(a)(iii), assets of a newly acquired subsidiary that are the equivalent of qualified assets in the subsidiary's domiciliary state, are, for the first five years after the subsidiary's acquisition, considered to be qualified assets under Section 31A-17-201. This assumption stands even if the assets are not otherwise qualified assets under Section 31A-17-201.

(b) A subsidiary formed or acquired to hold or manage investments that the parent insurance company might hold or manage directly, shall be valued as if the assets of the subsidiary were owned directly by the insurer in a percentage equal to the

insurer's percentage of ownership of the subsidiary. The subsidiary investment limitation of Subsection 31A-18-106(1)(k) does not apply to these subsidiaries.

(c) Subsidiaries other than those described in Subsections (3)(a) and (b) shall be valued in accordance with Subsection (1). The subsidiary investment limitation under Subsection 31A-18-106(1)(k) applies to these subsidiaries in the same manner as to subsidiaries described in Subsection (3)(a).

(d) In determining an insurer's financial condition, no value is given to:

(i) any interest held by the insurer in its own stock, including debts due the insurer that are secured by the insurer's own stock; or

(ii) any proportionate interest in the insurer's own stock, including debts that are secured by the insurer's own stock, which is held by any corporation, partnership, business unit, firm, or person owned in whole or in part by the insurer.

(4) The commissioner shall adopt rules to implement the provisions of this section.

Amended by Chapter 116, 2001 General Session

31A-17-402. Valuation of liabilities.

(1) Subject to this section, the commissioner shall make rules:

(a) specifying the liabilities required to be reported by an insurer in a financial statement submitted under Section 31A-2-202; and

(b) the methods of valuing the liabilities described in Subsection (1)(a).

(2) For life insurance, the methods of valuing specified pursuant to Subsection (1)(b) shall be consistent with Part 5, Standard Valuation Law.

(3) Title insurance reserves are provided for under Section 31A-17-408.

(4) In determining the financial condition of an insurer, liabilities include:

(a) the estimated amount necessary to pay:

(i) all the insurer's unpaid losses and claims incurred on or before the date of statement, whether reported or unreported; and

(ii) the expense of adjustment or settlement of a loss or claim described in this Subsection (4)(a);

(b) for life, accident and health insurance, and annuity contracts:

(i) the reserves on life insurance policies and annuity contracts in force, valued according to appropriate tables of mortality and the applicable rates of interest;

(ii) the reserves for accident and health benefits, for both active and disabled lives;

(iii) the reserves for accidental death benefits; and

(iv) any additional reserves:

(A) that may be required by the commissioner by rule; or

(B) if no rule is applicable under Subsection (4)(b)(iv)(A), in a manner consistent with the practice formulated or approved by the National Association of Insurance Commissioners with respect to those types of insurance;

(c) subject to Subsection (6), for insurance other than life, accident and health, and title insurance, the amount of reserves equal to the unearned portions of the gross premiums charged on policies in force, computed:

(i) on a daily or monthly pro rata basis; or

(ii) other basis approved by the commissioner;

(d) for ocean marine and other transportation insurance, reserves:

(i) equal to 50% of the amount of premiums upon risks covering not more than one trip or passage not terminated; and

(ii) computed:

(A) upon a pro rata basis; or

(B) with the commissioner's consent, in accordance with a method provided under Subsection (4)(c); and

(e) the insurer's other liabilities due or accrued at the date of statement including:

(i) taxes;

(ii) expenses; and

(iii) other obligations.

(5) (a) Except to the extent provided in Subsection (5)(b), in determining the financial condition of an insurer of workers' compensation insurance, the insurer's liabilities do not include any liability based on the liability of the Employer's Reinsurance Fund under Section 34A-2-702 for industrial accidents or occupational diseases occurring on or before June 30, 1994.

(b) Notwithstanding Subsection (5)(a), the liability of an insurer of workers' compensation insurance includes any premium assessment:

(i) imposed under Section 59-9-101; and

(ii) due at the date of statement.

(6) After adopting a method for computing the reserves described in Subsection (4)(c), an insurer may not change the method without the commissioner's written consent.

Amended by Chapter 306, 2007 General Session

31A-17-404. Credit allowed a domestic ceding insurer against reserves for reinsurance.

(1) A domestic ceding insurer is allowed credit for reinsurance as either an asset or a reduction from liability for reinsurance ceded only if the reinsurer meets the requirements of Subsection (3), (4), (5), (6), or (7), subject to the following:

(a) Credit is allowed under Subsection (3), (4), or (5) only with respect to a cession of a kind or class of business that the assuming insurer is licensed or otherwise permitted to write or assume:

(i) in its state of domicile; or

(ii) in the case of a United States branch of an alien assuming insurer, in the state through which it is entered and licensed to transact insurance or reinsurance.

(b) Credit is allowed under Subsection (5) or (6) only if the applicable requirements of Subsection (8) are met.

(2) A domestic ceding insurer is allowed credit for reinsurance ceded:

(a) only if the reinsurance is payable in a manner consistent with Section 31A-22-1201;

(b) only to the extent that the accounting:

(i) is consistent with the terms of the reinsurance contract; and

(ii) clearly reflects:

(A) the amount and nature of risk transferred; and

(B) liability, including contingent liability, of the ceding insurer;

(c) only to the extent the reinsurance contract shifts insurance policy risk from the ceding insurer to the assuming reinsurer in fact and not merely in form; and

(d) only if the reinsurance contract contains a provision placing on the reinsurer the credit risk of all dealings with intermediaries regarding the reinsurance contract.

(3) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is licensed to transact insurance or reinsurance in this state.

(4) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that is accredited as a reinsurer in this state.

(b) An insurer is accredited as a reinsurer if the insurer:

(i) files with the commissioner evidence of the insurer's submission to this state's jurisdiction;

(ii) submits to the commissioner's authority to examine the insurer's books and records;

(iii) (A) is licensed to transact insurance or reinsurance in at least one state; or

(B) in the case of a United States branch of an alien assuming insurer, is entered through and licensed to transact insurance or reinsurance in at least one state;

(iv) files annually with the commissioner a copy of the insurer's:

(A) annual statement filed with the insurance department of its state of domicile; and

(B) most recent audited financial statement; and

(v) (A) (I) has not had its accreditation denied by the commissioner within 90 days of the day on which the insurer submits the information required by this Subsection (4); and

(II) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; or

(B) (I) has its accreditation approved by the commissioner; and

(II) maintains a surplus with regard to policyholders in an amount less than $20,000,000.

(c) Credit may not be allowed a domestic ceding insurer if the assuming insurer's accreditation is revoked by the commissioner after a notice and hearing.

(5) (a) A domestic ceding insurer is allowed a credit if:

(i) the reinsurance is ceded to an assuming insurer that is:

(A) domiciled in a state meeting the requirements of Subsection (5)(a)(ii); or

(B) in the case of a United States branch of an alien assuming insurer, is entered through a state meeting the requirements of Subsection (5)(a)(ii);

(ii) the state described in Subsection (5)(a)(i) employs standards regarding credit for reinsurance substantially similar to those applicable under this section; and

(iii) the assuming insurer or United States branch of an alien assuming insurer:

(A) maintains a surplus with regard to policyholders in an amount not less than $20,000,000; and

(B) submits to the authority of the commissioner to examine its books and records.

(b) The requirements of Subsections (5)(a)(i) and (ii) do not apply to reinsurance

ceded and assumed pursuant to a pooling arrangement among insurers in the same holding company system.

(6) (a) A domestic ceding insurer is allowed a credit if the reinsurance is ceded to an assuming insurer that maintains a trust fund:

(i) created in accordance with rules made by the commissioner; and

(ii) in a qualified United States financial institution for the payment of a valid claim of:

(A) a United States ceding insurer of the assuming insurer;

(B) an assign of the United States ceding insurer; and

(C) a successor in interest to the United States ceding insurer.

(b) To enable the commissioner to determine the sufficiency of the trust fund described in Subsection (6)(a), the assuming insurer shall:

(i) report annually to the commissioner information substantially the same as that required to be reported on the National Association of Insurance Commissioners Annual Statement form by a licensed insurer; and

(ii) (A) submit to examination of its books and records by the commissioner; and

(B) pay the cost of an examination.

(c) (i) Credit for reinsurance may not be granted under this Subsection (6) unless the form of the trust and any amendment to the trust is approved by:

(A) the commissioner of the state where the trust is domiciled; or

(B) the commissioner of another state who, pursuant to the terms of the trust instrument, accepts principal regulatory oversight of the trust.

(ii) The form of the trust and an amendment to the trust shall be filed with the commissioner of every state in which a ceding insurer beneficiary of the trust is domiciled.

(iii) The trust instrument shall provide that a contested claim is valid and enforceable upon the final order of a court of competent jurisdiction in the United States.

(iv) The trust shall vest legal title to its assets in its one or more trustees for the benefit of:

(A) a United States ceding insurer of the assuming insurer;

(B) an assign of the United States ceding insurer; or

(C) a successor in interest to the United States ceding insurer.

(v) The trust and the assuming insurer are subject to examination as determined by the commissioner.

(vi) The trust shall remain in effect for as long as the assuming insurer has an outstanding obligation due under a reinsurance agreement subject to the trust.

(vii) No later than February 28 of each year, the trustee of the trust shall:

(A) report to the commissioner in writing the balance of the trust;

(B) list the trust's investments at the end of the preceding calendar year; and

(C) (I) certify the date of termination of the trust, if so planned; or

(II) certify that the trust will not expire prior to the following December 31.

(d) The following requirements apply to the following categories of assuming insurer:

(i) For a single assuming insurer:

(A) the trust fund shall consist of funds in trust in an amount not less than the

assuming insurer's liabilities attributable to reinsurance ceded by United States ceding insurers; and

(B) the assuming insurer shall maintain a trusteed surplus of not less than $20,000,000.

(ii) For a group acting as assuming insurer, including incorporated and individual unincorporated underwriters:

(A) for reinsurance ceded under a reinsurance agreement with an inception, amendment, or renewal date on or after August 1, 1995, the trust shall consist of a trusteed account in an amount not less than the group's several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to a member of the group;

(B) for reinsurance ceded under a reinsurance agreement with an inception date on or before July 31, 1995, and not amended or renewed after July 31, 1995, notwithstanding the other provisions of this chapter, the trust shall consist of a trusteed account in an amount not less than the group's several insurance and reinsurance liabilities attributable to business written in the United States;

(C) in addition to a trust described in Subsection (6)(d)(ii)(A) or (B), the group shall maintain in trust a trusteed surplus of which $100,000,000 is held jointly for the benefit of the one or more United States domiciled ceding insurers of a member of the group for all years of account;

(D) the incorporated members of the group:

(I) may not be engaged in a business other than underwriting as a member of the group; and

(II) are subject to the same level of regulation and solvency control by the group's domiciliary regulator as are the unincorporated members; and

(E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, the group shall provide to the commissioner:

(I) an annual certification by the group's domiciliary regulator of the solvency of each underwriter member; or

(II) if a certification is unavailable, a financial statement, prepared by an independent public accountant, of each underwriter member of the group.

(iii) For a group of incorporated underwriters under common administration, the group shall:

(A) have continuously transacted an insurance business outside the United States for at least three years immediately preceding the day on which the group makes application for accreditation;

(B) maintain aggregate policyholders' surplus of at least $10,000,000,000;

(C) maintain a trust fund in an amount not less than the group's several liabilities attributable to business ceded by the one or more United States domiciled ceding insurers to a member of the group pursuant to a reinsurance contract issued in the name of the group;

(D) in addition to complying with the other provisions of this Subsection (6)(d)(iii), maintain a joint trusteed surplus of which $100,000,000 is held jointly for the benefit of the one or more United States domiciled ceding insurers of a member of the group as additional security for these liabilities; and

(E) within 90 days after the day on which the group's financial statements are due to be filed with the group's domiciliary regulator, make available to the commissioner:

(I) an annual certification of each underwriter member's solvency by the member's domiciliary regulator; and

(II) a financial statement of each underwriter member of the group prepared by an independent public accountant.

(7) If reinsurance is ceded to an assuming insurer not meeting the requirements of Subsection (3), (4), (5), or (6), a domestic ceding insurer is allowed credit only as to the insurance of a risk located in a jurisdiction where the reinsurance is required by applicable law or regulation of that jurisdiction.

(8) Reinsurance credit may not be allowed a domestic ceding insurer unless the assuming insurer under the reinsurance contract submits to the jurisdiction of Utah courts by:

(a) (i) being an admitted insurer; and

(ii) submitting to jurisdiction under Section 31A-2-309;

(b) having irrevocably appointed the commissioner as the domestic ceding insurer's agent for service of process in an action arising out of or in connection with the reinsurance, which appointment is made under Section 31A-2-309; or

(c) agreeing in the reinsurance contract:

(i) that if the assuming insurer fails to perform its obligations under the terms of the reinsurance contract, the assuming insurer, at the request of the ceding insurer, shall:

(A) submit to the jurisdiction of a court of competent jurisdiction in a state of the United States;

(B) comply with all requirements necessary to give the court jurisdiction; and

(C) abide by the final decision of the court or of an appellate court in the event of an appeal; and

(ii) to designate the commissioner or a specific attorney licensed to practice law in this state as its attorney upon whom may be served lawful process in an action, suit, or proceeding instituted by or on behalf of the ceding company.

(9) Submitting to the jurisdiction of Utah courts under Subsection (8) does not override a duty or right of a party under the reinsurance contract, including a requirement that the parties arbitrate their disputes.

(10) If an assuming insurer does not meet the requirements of Subsection (3), (4), or (5), the credit permitted by Subsection (6) may not be allowed unless the assuming insurer agrees in the trust instrument to the following conditions:

(a) (i) Notwithstanding any other provision in the trust instrument, if an event described in Subsection (10)(a)(ii) occurs the trustee shall comply with:

(A) an order of the commissioner with regulatory oversight over the trust; or

(B) an order of a court of competent jurisdiction directing the trustee to transfer to the commissioner with regulatory oversight all of the assets of the trust fund.

(ii) This Subsection (10)(a) applies if:

(A) the trust fund is inadequate because the trust contains an amount less than the amount required by Subsection (6)(d); or

(B) the grantor of the trust is:

(I) declared insolvent; or

(II) placed into receivership, rehabilitation, liquidation, or similar proceeding under the laws of its state or country of domicile.

(b) The assets of a trust fund described in Subsection (10)(a) shall be distributed by and a claim shall be filed with and valued by the commissioner with regulatory oversight in accordance with the laws of the state in which the trust is domiciled that are applicable to the liquidation of a domestic insurance company.

(c) If the commissioner with regulatory oversight determines that the assets of the trust fund, or any part of the assets, are not necessary to satisfy the claims of the one or more United States ceding insurers of the grantor of the trust, the assets, or a part of the assets, shall be returned by the commissioner with regulatory oversight to the trustee for distribution in accordance with the trust instrument.

(d) A grantor shall waive any right otherwise available to it under United States law that is inconsistent with this Subsection (10).

Amended by Chapter 257, 2008 General Session

31A-17-404.1. Asset or reduction from liability for reinsurance ceded by a domestic insurer to other assuming insurers.

(1) (a) An asset or a reduction from liability for reinsurance ceded by a domestic insurer to an assuming insurer that does not meet the requirements of Section 31A-17-404 is allowed in an amount not exceeding the liabilities carried by the ceding insurer.

(b) A reduction described in Subsection (1)(a) shall be in the amount of funds held by or on behalf of the ceding insurer, including funds held in trust for the ceding insurer:

(i) that are held:

(A) under a reinsurance contract with the assuming insurer; and

(B) as security for the payment of obligations under the reinsurance contract; and

(ii) if the security is held:

(A) in the United States subject to withdrawal solely by, and under the exclusive control of, the ceding insurer; or

(B) in the case of a trust, in a qualified United States financial institution.

(2) Security described in Subsection (1) may be in the form of:

(a) cash;

(b) a security:

(i) listed by the Securities Valuation Office of the National Association of Insurance Commissioners; and

(ii) qualifying as an admitted asset;

(c) subject to Subsection (3), a clean, irrevocable, unconditional letter of credit, issued or confirmed by a qualified United States financial institution:

(i) effective no later than December 31 of the year for which the filing is being made; and

(ii) in the possession of, or in trust for, the ceding company on or before the filing date of its annual statement; or

(d) another form of security acceptable to the commissioner.

(3) Notwithstanding an issuing or confirming institution's subsequent failure to meet an applicable standard of acceptability, a letter of credit described in Subsection (2) that meets the applicable standards of issuer acceptability as of the day on which it is issued or confirmed shall continue to be acceptable as security until the sooner of the day on which the letter of credit expires, is extended, is renewed, is modified, or is amended.

Enacted by Chapter 257, 2008 General Session

31A-17-404.2. Credit allowed a foreign ceding insurer.

(1) A foreign ceding insurer is allowed a credit for reinsurance or reduction from liability to the extent that credit is allowed by the ceding insurer's state of domicile if:

(a) the state of domicile is accredited by the National Association of Insurance Commissioners; or

(b) credit or reduction from liability would be allowed under this section if the foreign ceding insurer were domiciled in this state.

(2) Credit for reinsurance or reduction from liability may be disallowed a foreign ceding insurer upon a finding by the commissioner that one or more of the following do not satisfy the credit for reinsurance requirements of this chapter applicable to a ceding insurer domiciled in this state:

(a) the condition of the reinsurer; or

(b) the collateral or other security provided by the reinsurer.

Enacted by Chapter 257, 2008 General Session

31A-17-404.3. Rules.

In accordance with Title 63G, Chapter 3, Utah Administrative Rulemaking Act, and this chapter, the commissioner may make rules prescribing:

(1) the form of a letter of credit required under this chapter;

(2) the requirements for a trust or trust instrument required by this chapter;

(3) the procedures for licensing and accrediting; and

(4) minimum capital and surplus requirements.

Enacted by Chapter 257, 2008 General Session

31A-17-404.4. Transition -- Application to reinsurance agreement.

The amendments to this part made in Laws of Utah 2008, Chapter 257, apply to a cession made on or after July 1, 2008 under a reinsurance contract that has an inception, anniversary, or renewal date no sooner than January 1, 2009.

Enacted by Chapter 257, 2008 General Session

31A-17-405. Fraternal rates and reserves.

(1) A fraternal may be organized for the transaction of business on a plan set forth in the contract which provides for sufficient contributions by each member each

year to pay the member's share of the actual death claims of the year, through advance payments graded according to a mortality table approved by the commissioner, without any reserve, or with a reserve which may accumulate from overpayments of individual members. If this type of reserve does accumulate, each member shall be informed each year of the member's credit and of the cost of the member's insurance.

(2) Each fraternal shall collect regular premiums for each coverage it provides at adequate rates that are approved by the commissioner or conform to standards set by rules adopted by the commissioner.

(3) The reserves of a fraternal are subject to the same requirements as those of Chapter 5 insurers writing the same coverages, except that the commissioner may authorize the use of suitable fraternal mortality tables or other appropriate tables instead of the tables used by Chapter 5 insurers.

Enacted by Chapter 242, 1985 General Session

31A-17-406. Adjustment of reserves.

The commissioner may order an insurer to adjust its reserves so the reserves bear a reasonable actuarial relationship to the insurer's obligations.

Enacted by Chapter 242, 1985 General Session

31A-17-407. Accounting for repurchased shares.

When a corporation acquires its own shares under Section 31A-5-306 or in any other way, the acquired shares are accounted as a deduction from capital and not as assets.

Enacted by Chapter 242, 1985 General Session

31A-17-408. Title insurance reserves.

(1) In addition to an adequate reserve for outstanding losses, a title insurance company shall either:

(a) maintain and segregate an unearned premium reserve fund of not less than 10 cents for each $1,000 face amount of retained liability under each title insurance contract or policy on a single insurance risk issued; or

(b) have the commissioner review and approve a contract of reinsurance applicable to the title insurance company's policies, which contract adequately covers the exposure or risk which the unearned premium reserve would serve.

(2) The fund shall be maintained for the protection of policyholders and is not subject to the claims of stockholders or creditors other than policyholders.

Amended by Chapter 116, 2001 General Session

31A-17-501. Standard Valuation Law.

This part is known as the "Standard Valuation Law."

Enacted by Chapter 305, 1993 General Session

31A-17-502. Reserve valuation.

The commissioner shall annually value, or cause to be valued, the reserve liabilities (also called "reserves" in this part) for all outstanding life insurance policies and annuity and pure endowment contracts of every life insurance company doing business in this state, and may certify the amount of any such reserves, specifying the mortality table or tables, rate or rates of interest, and methods (net level premium method or other) used in the calculation of such reserves. In calculating such reserves, he may use group methods and approximate averages for fractions of a year or otherwise. In lieu of the valuation of the reserves required in this part of any foreign or alien company, he may accept any valuation made, or caused to be made, by the insurance supervisory official of any state or other jurisdiction when such valuation complies with the minimum standard provided in this part, and if the official of such state or jurisdiction accepts as sufficient and for all valid legal purposes the certificate of valuation of the commissioner when such certificate states the valuation to have been made in a specified manner according to which the aggregate reserves would be at least as large as if they had been computed in the manner prescribed by the law of that state or jurisdiction.

Enacted by Chapter 305, 1993 General Session

31A-17-503. Actuarial opinion of reserves.

(1) This section becomes operative on December 31, 1993.

(2) General: Every life insurance company doing business in this state shall annually submit the opinion of a qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule are computed appropriately, are based on assumptions which satisfy contractual provisions, are consistent with prior reported amounts, and comply with applicable laws of this state. The commissioner by rule shall define the specifics of this opinion and add any other items considered to be necessary to its scope.

(3) Actuarial analysis of reserves and assets supporting reserves:

(a) Every life insurance company, except as exempted by or pursuant to rule, shall also annually include in the opinion required by Subsection (2), an opinion of the same qualified actuary as to whether the reserves and related actuarial items held in support of the policies and contracts specified by the commissioner by rule, when considered in light of the assets held by the company with respect to the reserves and related actuarial items, including the investment earnings on the assets and the considerations anticipated to be received and retained under the policies and contracts, make adequate provision for the company's obligations under the policies and contracts, including the benefits under the expenses associated with the policies and contracts.

(b) The commissioner may provide by rule for a transition period for establishing any higher reserves which the qualified actuary may consider necessary in order to render the opinion required by this section.

(4) Requirement for opinion under Subsection (3): Each opinion required by Subsection (3) shall be governed by the following provisions:

(a) A memorandum, in form and substance acceptable to the commissioner as

specified by rule, shall be prepared to support each actuarial opinion.

(b) If the insurance company fails to provide a supporting memorandum at the request of the commissioner within a period specified by rule or the commissioner determines that the supporting memorandum provided by the insurance company fails to meet the standards prescribed by the rule or is otherwise unacceptable to the commissioner, the commissioner may engage a qualified actuary at the expense of the company to review the opinion and the basis for the opinion and prepare such supporting memorandum as is required by the commissioner.

(5) Requirement for all opinions: Every opinion shall be governed by the following provisions:

(a) The opinion shall be submitted with the annual statement reflecting the valuation of the reserve liabilities for each year ending on or after December 31, 1993.

(b) The opinion shall apply to all business in force including individual and group health insurance plans, in form and substance acceptable to the commissioner as specified by rule.

(c) The opinion shall be based on standards adopted from time to time by the Actuarial Standards Board and on such additional standards as the commissioner may by rule prescribe.

(d) In the case of an opinion required to be submitted by a foreign or alien company, the commissioner may accept the opinion filed by that company with the insurance supervisory official of another state if the commissioner determines that the opinion reasonably meets the requirements applicable to a company domiciled in this state.

(e) For the purposes of this section, "qualified actuary" means a member in good standing of the American Academy of Actuaries who meets the requirements set forth by department rule.

(f) Except in cases of fraud or willful misconduct, the qualified actuary is not liable for damages to any person, other than the insurance company and the commissioner, for any act, error, omission, decision, or conduct with respect to the actuary's opinion.

(g) Disciplinary action by the commissioner against the company or the qualified actuary shall be defined in rules by the commissioner.

(h) Any memorandum in support of the opinion, and any other material provided by the company to the commissioner in connection therewith, are considered protected records under Section 63G-2-305 and may not be made public and are not subject to subpoena under Subsection 63G-2-202(7), other than for the purpose of defending an action seeking damages from any person by reason of any action required by this section or rules promulgated under this section. However, the memorandum or other material may otherwise be released by the commissioner (i) with the written consent of the company or (ii) to the American Academy of Actuaries upon request stating that the memorandum or other material is required for the purpose of professional disciplinary proceedings and setting forth procedures satisfactory to the commissioner for preserving the confidentiality of the memorandum or other material. Once any portion of the confidential memorandum is cited in its marketing or is cited before any governmental agency other than the department or is released to the news media, all portions of the memorandum are no longer confidential.

Amended by Chapter 297, 2011 General Session

31A-17-504. Computation of minimum standard.

Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and 31A-17-513, the minimum standard for the valuation of all life insurance policies and annuity and pure endowment contracts issued prior to January 1, 1994, shall be that provided by the laws in effect immediately prior to that date. Except as otherwise provided in Sections 31A-17-505, 31A-17-506, and 31A-17-513, the minimum standard for the valuation of all such policies and contracts issued on or after January 1, 1994, shall be the commissioner's reserve valuation methods defined in Sections 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-513, 3.5% interest, or in the case of life insurance policies and contracts, other than annuity and pure endowment contracts, issued on or after June 1, 1973, 4% interest for such policies issued prior to April 2, 1980, 5.5% interest for single premium life insurance policies, and 4.5% interest for all other such policies issued on and after April 2, 1980, and the following tables:

(1) For all ordinary policies of life insurance issued on the standard basis, excluding any accident and health and accidental death benefits in such policies: the National Association of Insurance Commissioners 1941 Standard Ordinary Mortality Table for such policies issued prior to the operative date of Subsection 31A-22-408(6)(a) (that is, the Standard Nonforfeiture Law for Life Insurance), the National Association of Insurance Commissioners 1958 Standard Ordinary Mortality Table for such policies issued on or after the operative date of Subsection 31A-22-408(6)(a) and prior to the operative date of Subsection 31A-22-408(6)(d), provided that for any category of such policies issued on female risks, all modified net premiums and present values referred to in this section may be calculated according to an age not more than six years younger than the actual age of the insured; and for such policies issued on or after the operative date of Subsection 31A-22-408(6)(d):

(a) the National Association of Insurance Commissioners 1980 Standard Ordinary Mortality Table;

(b) at the election of the company for any one or more specified plans of life insurance, the National Association of Insurance Commissioners 1980 Standard Ordinary Mortality Table with Ten-Year Select Mortality Factors; or

(c) any ordinary mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.

(2) For all industrial life insurance policies issued on the standard basis, excluding any accident and health and accidental death benefits in such policies: the 1941 Standard Industrial Mortality Table for such policies issued prior to the operative date of Subsection 31A-22-408(6)(c), and for such policies issued on or after such operative date, the National Association of Insurance Commissioners 1961 Standard Industrial Mortality Table or any industrial mortality table, adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies.

(3) For individual annuity and pure endowment contracts, excluding any disability and accidental death benefits in such policies:

(a) the 1937 Standard Annuity Mortality Table;

(b) at the option of the company, the Annuity Mortality Table for 1949, Ultimate; or

(c) any modification of either of these tables approved by the commissioner.

(4) For group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits in such policies:

(a) the Group Annuity Mortality Table for 1951, any modification of such table approved by the commissioner; or

(b) at the option of the company, any of the tables or modifications of tables specified for individual annuity and pure endowment contracts.

(5) For total and permanent disability benefits in or supplementary to ordinary policies or contracts: for policies or contracts issued on or after January 1, 1966, the tables of Period 2 disablement rates and the 1930 to 1950 termination rates of the 1952 Disability Study of the Society of Actuaries, with due regard to the type of benefit or any tables of disablement rates and termination rates adopted after 1980 by the National Association of Insurance Commissioners, that are approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies; for policies or contracts issued on or after January 1, 1961, and prior to January 1, 1966, either such tables or, at the option of the company, the Class (3) Disability Table (1926); and for policies issued prior to January 1, 1961, the Class (3) Disability Table (1926). Any such table shall, for active lives, be combined with a mortality table permitted for calculating the reserves for life insurance policies.

(6) For accidental death benefits in or supplementary to policies issued on or after January 1, 1966, the 1959 Accidental Death Benefits Table or any accidental death benefits table adopted after 1980 by the National Association of Insurance Commissioners, that is approved by rule promulgated by the commissioner for use in determining the minimum standard of valuation for such policies, for policies issued on or after January 1, 1961, and prior to January 1, 1966, either such table or, at the option of the company, the Inter-Company Double Indemnity Mortality Table; and for policies issued prior to January 1, 1961, the Inter-Company Double Indemnity Mortality Table. Either table shall be combined with a mortality table for calculating the reserves for life insurance policies.

(7) For group life insurance, life insurance issued on the substandard basis and other special benefits: such tables as may be approved by the commissioner.

Amended by Chapter 116, 2001 General Session

31A-17-505. Computation of minimum standard for annuities.

(1) Except as provided in Section 31A-17-506, the minimum standard for the valuation of all individual annuity and pure endowment contracts issued on or after the operative date of this section, as defined in Subsection (2), and for all annuities and pure endowments purchased on or after such operative date under group annuity and pure endowment contracts, shall be the commissioner's reserve valuation methods defined in Sections 31A-17-507 and 31A-17-508 and the following tables and interest

rates:

(a) for individual annuity and pure endowment contracts issued prior to April 2, 1980, excluding any accident and health and accidental death benefits in the contracts:

(i) (A) the 1971 Individual Annuity Mortality Table; or

(B) any modification of the 1971 Individual Annuity Mortality Table approved by the commissioner;

(ii) 6% interest for single premium immediate annuity contracts; and

(iii) 4% interest for all other individual annuity and pure endowment contracts;

(b) for individual single premium immediate annuity contracts issued on or after April 2, 1980, excluding any accident and health and accidental death benefits in the contracts:

(i) (A) any individual annuity mortality table that is approved by rule by the commissioner for use in determining the minimum standard of valuation for such contracts; or

(B) any modification of a table described in Subsection (1)(b)(i)(A) approved by the commissioner; and

(ii) 7.5% interest;

(c) for individual annuity and pure endowment contracts issued on or after April 2, 1980, other than single premium immediate annuity contracts, excluding any accident and health and accidental death benefits in the contracts:

(i) (A) any individual annuity mortality table that is approved by rule by the commissioner for use in determining the minimum standard of valuation for such contracts; or

(B) any modification of a table described in Subsection (1)(c)(i)(A) approved by the commissioner;

(ii) 5.5% interest for single premium deferred annuity and pure endowment contracts; and

(iii) 4.5% interest for all other such individual annuity and pure endowment contracts;

(d) for all annuities and pure endowments purchased prior to April 2, 1980, under group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits purchased under the contracts:

(i) (A) the 1971 Group Annuity Mortality Table; or

(B) any modification of the 1971 Group Annuity Mortality Table approved by the commissioner; and

(ii) 6.5% interest; and

(e) for all annuities and pure endowments purchased on or after April 2, 1980, under group annuity and pure endowment contracts, excluding any accident and health and accidental death benefits purchased under the contracts:

(i) (A) any group annuity mortality table that is approved by rule by the commissioner for use in determining the minimum standard of valuation for such annuities and pure endowments; or

(B) any modification of a table described in Subsection (1)(e)(i)(A) approved by the commissioner; and

(ii) 7.5% interest.

(2) (a) After June 1, 1973, any company may file with the commissioner a

written notice of its election to comply with this section after a specified date before January 1, 1979, which shall be the operative date of this section for the company.

(b) If a company does not make an election under Subsection (2)(a), the operative date of this section for the company shall be January 1, 1979.

Amended by Chapter 308, 2002 General Session

31A-17-506. Computation of minimum standard by calendar year of issue.

(1) Applicability of Section 31A-17-506: The interest rates used in determining the minimum standard for the valuation shall be the calendar year statutory valuation interest rates as defined in this section for:

(a) all life insurance policies issued in a particular calendar year, on or after the operative date of Subsection 31A-22-408(6)(d);

(b) all individual annuity and pure endowment contracts issued in a particular calendar year on or after January 1, 1982;

(c) all annuities and pure endowments purchased in a particular calendar year on or after January 1, 1982, under group annuity and pure endowment contracts; and

(d) the net increase, if any, in a particular calendar year after January 1, 1982, in amounts held under guaranteed interest contracts.

(2) Calendar year statutory valuation interest rates:

(a) The calendar year statutory valuation interest rates, "I," shall be determined as follows and the results rounded to the nearer 1/4 of 1%:

(i) for life insurance:

I = .03 + W(R1 - .03) + (W/2)(R2 - .09);

(ii) for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and from guaranteed interest contracts with cash settlement options:

I = .03 + W(R - .03),

where R1 is the lesser of R and .09,

R2 is the greater of R and .09,

R is the reference interest rate defined in Subsection (4), and

W is the weighting factor defined in this section;

(iii) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on an issue year basis, except as stated in Subsection (2)(a)(ii), the formula for life insurance stated in Subsection (2)(a)(i) shall apply to annuities and guaranteed interest contracts with guarantee durations in excess of 10 years, and the formula for single premium immediate annuities stated in Subsection (2)(a)(ii) shall apply to annuities and guaranteed interest contracts with guarantee duration of 10 years or less;

(iv) for other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the formula for single premium immediate annuities stated in Subsection (2)(a)(ii) shall apply; and

(v) for other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, the formula for single premium immediate annuities stated in Subsection (2)(a)(ii) shall apply.

(b) However, if the calendar year statutory valuation interest rate for any life

insurance policies issued in any calendar year determined without reference to this sentence differs from the corresponding actual rate for similar policies issued in the immediately preceding calendar year by less than one-half of 1% the calendar year statutory valuation interest rate for such life insurance policies shall be equal to the corresponding actual rate for the immediately preceding calendar year. For purposes of applying the immediately preceding sentence, the calendar year statutory valuation interest rate for life insurance policies issued in a calendar year shall be determined for 1980, using the reference interest rate defined in 1979, and shall be determined for each subsequent calendar year regardless of when Subsection 31A-22-408(6)(d) becomes operative.

(3) Weighting factors:

(a) The weighting factors referred to in the formulas stated in Subsection (2) are given in the following tables:

(i) (A) Weighting factors for life insurance:

Guarantee Duration (Years)	Weighting Factors
10 or less:	.50
More than 10, but less than 20:	.45
More than 20:	.35

(B) For life insurance, the guarantee duration is the maximum number of years the life insurance can remain in force on a basis guaranteed in the policy or under options to convert to plans of life insurance with premium rates or nonforfeiture values or both which are guaranteed in the original policy;

(ii) Weighting factor for single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options: .80

(iii) Weighting factors for other annuities and for guaranteed interest contracts, except as stated in Subsection (3)(a)(ii), shall be as specified in the tables in Subsections (3)(a)(iii)(A), (B), and (C), according to the rules and definitions in Subsection (3)(b):

(A) For annuities and guaranteed interest contracts valued on an issue year basis:

Guarantee Duration (Years)	Weighting Factors for Plan Type		
	A	B	C
5 or less:	.80	.60	.50
More than 5, but not more than 10:	.75	.60	.50
More than 10, but not more than 20:	.65	.50	.45
More than 20:	.45	.35	.35

Plan Type

	A	B	C
(B) For annuities and guaranteed interest contracts valued on a change in fund basis, the factors shown in Subsection (3)(a)(iii)(A) increased by:	.15	.25	.05

	Plan Type		
	A	B	C
(C) For annuities and guaranteed interest contracts valued on an issue year basis, other than those with no cash settlement options, which do not guarantee interest on considerations received more than one year after issue or purchase and for annuities and guaranteed interest contracts valued on a change in fund basis which do not guarantee interest rates on considerations received more than 12 months beyond the valuation date, the factors shown in Subsection (3)(a)(iii)(A) or derived in Subsection (3)(a)(iii)(B) increased by:	.05	.05	.05.

(b) (i) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the guarantee duration is the number of years for which the contract guarantees interest rates in excess of the calendar year statutory valuation interest rate for life insurance policies with guarantee duration in excess of 20 years. For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the guaranteed duration is the number of years from the date of issue or date of purchase to the date annuity benefits are scheduled to commence.

(ii) Plan type as used in the above tables is defined as follows:

(A) Plan Type A: At any time policyholder may withdraw funds only:

(I) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(II) without such adjustment but installments over five years or more;

(III) as an immediate life annuity; or

(IV) no withdrawal permitted.

(B) (I) Plan Type B: Before expiration of the interest rate guarantee, policyholder withdraw funds only:

(Aa) with an adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company;

(Bb) without such adjustment but in installments over five years or more; or

(Cc) no withdrawal permitted.

(II) At the end of interest rate guarantee, funds may be withdrawn without such adjustment in a single sum or installments over less than five years.

(C) Plan Type C: Policyholder may withdraw funds before expiration of interest rate guarantee in a single sum or installments over less than five years either:

(I) without adjustment to reflect changes in interest rates or asset values since receipt of the funds by the insurance company; or

(II) subject only to a fixed surrender charge stipulated in the contract as a percentage of the fund.

(iii) A company may elect to value guaranteed interest contracts with cash settlement options and annuities with cash settlement options on either an issue year basis or on a change in fund basis. Guaranteed interest contracts with no cash settlement options and other annuities with no cash settlement options shall be valued on an issue year basis. As used in this section, an issue year basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard for the entire duration of the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of issue or year of purchase of the annuity or guaranteed interest contract, and the change in fund basis of valuation refers to a valuation basis under which the interest rate used to determine the minimum valuation standard applicable to each change in the fund held under the annuity or guaranteed interest contract is the calendar year valuation interest rate for the year of the change in the fund.

(4) Reference interest rate: "Reference interest rate" referred to in Subsection (2)(a) is defined as follows:

(a) For all life insurance, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year next preceding the year of issue, of the Monthly Average of the composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(b) For single premium immediate annuities and for annuity benefits involving life contingencies arising from other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or year of purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(c) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Subsection (4)(b), with guarantee duration in excess of 10 years, the lesser of the average over a period of 36 months and the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(d) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a year of issue basis, except as stated in Subsection (4)(b), with guarantee duration of 10 years or less, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(e) For other annuities with no cash settlement options and for guaranteed interest contracts with no cash settlement options, the average over a period of 12 months, ending on June 30 of the calendar year of issue or purchase, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by

Moody's Investors Service, Inc.

(f) For other annuities with cash settlement options and guaranteed interest contracts with cash settlement options, valued on a change in fund basis, except as stated in Subsection (4)(b), the average over a period of 12 months, ending on June 30 of the calendar year of the change in the fund, of the Monthly Average of the Composite Yield on Seasoned Corporate Bonds, as published by Moody's Investors Service, Inc.

(5) Alternative method for determining reference interest rates: In the event that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds is no longer published by Moody's Investors Service, Inc. or in the event that the National Association of Insurance Commissioners determines that the Monthly Average of the Composite Yield on Seasoned Corporate Bonds as published by Moody's Investors Service, Inc. is no longer appropriate for the determination of the reference interest rate, then an alternative method for determination of the reference interest rate, which is adopted by the National Association of Insurance Commissioners and approved by rule promulgated by the commissioner, may be substituted.

Amended by Chapter 297, 2011 General Session

31A-17-507. Reserve valuation method -- Life insurance and endowment benefits.

(1) Except as otherwise provided in Sections 31A-17-508, 31A-17-511, and 31A-17-513, reserves according to the commissioner's reserve valuation method, for the life insurance and endowment benefits of policies providing for a uniform amount of insurance and requiring the payment of uniform premiums shall be the excess, if any, of the present value, at the date of valuation, of such future guaranteed benefits provided for by such policies, over the then present value of any future modified net premiums therefor. The modified net premiums for any such policy shall be such uniform percentage of the respective contract premiums for such benefits that the present value, at the date of issue of the policy, of all such modified net premiums shall be equal to the sum of the then present value of such benefits provided for by the policy and the excess of Subsection (1)(a) over Subsection (1)(b), as follows:

(a) A net level annual premium equal to the present value, at the date of issue, of such benefits provided for after the first policy year, divided by the present value, at the date of issue, of an annuity of one per annum payable on the first and each subsequent anniversary of such policy on which a premium falls due; provided, however, that such net level annual premium may not exceed the net level annual premium on the 19 year premium whole life plan for insurance of the same amount at an age one year higher than the age at issue of such policy.

(b) A net one year term premium for such benefits provided for in the first policy year.

(2) Provided that for any life insurance policy issued on or after January 1, 1997, for which the contract premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the reserve according to the commissioner's reserve valuation method as of any policy anniversary

occurring on or before the assumed ending date defined herein as the first policy anniversary on which the sum of any endowment benefit and any cash surrender value then available is greater than such excess premium shall, except as otherwise provided in Section 31A-17-511, be the greater of the reserve as of such policy anniversary calculated as described in Subsection (1) and the reserve as of such policy anniversary calculated as described in that subsection, but with:

(a) the value defined in Subsection (1)(a) being reduced by 15% of the amount of such excess first year premium;

(b) all present values of benefits and premiums being determined without reference to premiums or benefits provided for by the policy after the assumed ending date;

(c) the policy being assumed to mature on such date as an endowment; and

(d) the cash surrender value provided on such date being considered as an endowment benefit. In making the above comparison the mortality and interest bases stated in Sections 31A-17-504 and 31A-17-506 shall be used.

(3) Reserves according to the commissioner's reserve valuation method for:

(a) life insurance policies providing for a varying amount of insurance or requiring the payment of varying premiums;

(b) group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code;

(c) accident and health and accidental death benefits in all policies and contracts; and

(d) all other benefits, except life insurance and endowment benefits in life insurance policies and benefits provided by all other annuity and pure endowment contracts, shall be calculated by a method consistent with the principles of Subsections (1) and (2).

Amended by Chapter 297, 2011 General Session

31A-17-508. Reserve valuation method -- Annuity and pure endowment benefits.

(1) This section shall apply to all annuity and pure endowment contracts other than group annuity and pure endowment contracts purchased under a retirement plan or plan of deferred compensation, established or maintained by an employer, including a partnership or sole proprietorship, or by an employee organization, or by both, other than a plan providing individual retirement accounts or individual retirement annuities under Section 408, Internal Revenue Code.

(2) Reserves according to the commissioner's annuity reserve method for benefits under annuity or pure endowment contracts, excluding any accident and health and accidental death benefits in such contracts, shall be the greatest of the respective excesses of the present values, at the date of valuation, of the future guaranteed benefits, including guaranteed nonforfeiture benefits, provided for by such contracts at the end of each respective contract year, over the present value, at the date of

valuation, of any future valuation considerations derived from future gross considerations, required by the terms of such contract, that become payable prior to the end of such respective contract year. The future guaranteed benefits shall be determined by using the mortality table, if any, and the interest rate, or rates, specified in such contracts for determining guaranteed benefits. The valuation considerations are the portions of the respective gross considerations applied under the terms of such contracts to determine nonforfeiture values.

Amended by Chapter 116, 2001 General Session

31A-17-509. Minimum reserves.

(1) In no event shall a company's aggregate reserves for all life insurance policies, excluding accident and health and accidental death benefits, issued on or after January 1, 1994, be less than the aggregate reserves calculated in accordance with the methods set forth in Sections 31A-17-507, 31A-17-508, 31A-17-511, and 31A-17-512 and the mortality table or tables and rate or rates of interest used in calculating nonforfeiture benefits for such policies.

(2) In no event shall the aggregate reserves for all policies, contracts, and benefits be less than the aggregate reserves determined by the qualified actuary to be necessary to render the opinion required by Section 31A-17-503.

Amended by Chapter 116, 2001 General Session

31A-17-510. Optional reserve calculation.

(1) Reserves for all policies and contracts issued prior to January 1, 1994, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for all such policies and contracts than the minimum reserves required by the laws in effect immediately prior to that date. Reserves for any category of policies, contracts, or benefits as established by the commissioner, issued on or after January 1, 1994, may be calculated, at the option of the company, according to any standards which produce greater aggregate reserves for such category than those calculated according to the minimum standard herein provided, but the rate or rates of interest used for policies and contracts, other than annuity and pure endowment contracts, may not be higher than the corresponding rate or rates of interest used in calculating any nonforfeiture benefits provided therein.

(2) Any such company which at any time shall have adopted any standard of valuation producing greater aggregate reserves than those calculated according to the minimum standard herein provided may, with the approval of the commissioner, adopt any lower standard of valuation, but not lower than the minimum herein provided; provided, however, that, for the purposes of this section, the holding of additional reserves previously determined by a qualified actuary to be necessary to render the opinion required by Section 31A-17-502 may not be considered to be the adoption of a higher standard of valuation.

Amended by Chapter 297, 2011 General Session

31A-17-511. Reserve calculation -- Valuation net premium exceeding the gross premium charged.

(1) If in any contract year the gross premium charged by any life insurance company on any policy or contract is less than the valuation net premium for the policy or contract calculated by the method used in calculating the reserve thereon but using the minimum valuation standards of mortality and rate of interest, the minimum reserve required for such policy or contract shall be the greater of either the reserve calculated according to the mortality table, rate of interest, and method actually used for such policy or contract, or the reserve calculated by the method actually used for such policy or contract but using the minimum valuation standards of mortality and rate of interest and replacing the valuation net premium by the actual gross premium in each contract year for which the valuation net premium exceeds the actual gross premium. The minimum valuation standards of mortality and rate of interest referred to in this section are those standards stated in Sections 31A-17-504 and 31A-17-506.

(2) Provided that for any life insurance policy issued on or after January 1, 1997, for which the gross premium in the first policy year exceeds that of the second year and for which no comparable additional benefit is provided in the first year for such excess and which provides an endowment benefit or a cash surrender value or a combination thereof in an amount greater than such excess premium, the foregoing provisions of this section shall be applied as if the method actually used in calculating the reserve for such policy were the method described in Section 31A-17-507, ignoring Subsection 31A-17-507(2). The minimum reserve at each policy anniversary of such a policy shall be the greater of the minimum reserve calculated in accordance with Section 31A-17-507, including Subsection 31A-17-507(2), and the minimum reserve calculated in accordance with this section.

Enacted by Chapter 305, 1993 General Session

31A-17-512. Reserve calculation -- Indeterminate premium plans.

(1) In the case of any plan of life insurance which provides for future premium determination, the amounts of which are to be determined by the insurance company based on then estimates of future experience, or in the case of any plan of life insurance or annuity which is of such a nature that the minimum reserves cannot be determined by the methods described in Sections 31A-17-507, 31A-17-508, and 31A-17-511, the reserves which are held under any such plan shall:

(a) be appropriate in relation to the benefits and the pattern of premiums for that plan; and

(b) be computed by a method which is consistent with the principles of this part, as determined by rules promulgated by the commissioner.

Amended by Chapter 297, 2011 General Session

31A-17-513. Minimum standards for accident and health plans.

The commissioner shall promulgate a rule containing the minimum standards applicable to the valuation of accident and health plans.

Amended by Chapter 116, 2001 General Session

31A-17-601. Definitions.

As used in this part:

(1) "Adjusted RBC report" means an RBC report that has been adjusted by the commissioner in accordance with Subsection 31A-17-602(5).

(2) "Corrective order" means an order issued by the commissioner specifying corrective action that the commissioner determines is required.

(3) "Health organization" means:

(a) an entity that is authorized under Chapter 7 or 8; and

(b) that is:

(i) a health maintenance organization;

(ii) a limited health service organization;

(iii) a dental or vision plan;

(iv) a hospital, medical, and dental indemnity or service corporation; or

(v) other managed care organization.

(4) "Life or accident and health insurer" means:

(a) an insurance company licensed to write life insurance, disability insurance, or both; or

(b) a licensed property casualty insurer writing only disability insurance.

(5) "Property and casualty insurer" means any insurance company licensed to write lines of insurance other than life but does not include a monoline mortgage guaranty insurer, financial guaranty insurer, or title insurer.

(6) "RBC" means risk-based capital.

(7) "RBC instructions" means the RBC report including risk-based capital instructions adopted by the department by rule.

(8) "RBC level" means an insurer's or health organization's authorized control level RBC, company action level RBC, mandatory control level RBC, or regulatory action level RBC.

(a) "Authorized control level RBC" means the number determined under the risk-based capital formula in accordance with the RBC instructions;

(b) "Company action level RBC" means the product of 2.0 and its authorized control level RBC;

(c) "Mandatory control level RBC" means the product of .70 and the authorized control level RBC; and

(d) "Regulatory action level RBC" means the product of 1.5 and its authorized control level RBC.

(9) (a) "RBC plan" means a comprehensive financial plan containing the elements specified in Subsection 31A-17-603(2).

(b) Notwithstanding Subsection (9)(a), the plan is a "revised RBC plan" if:

(i) the commissioner rejects the RBC plan; and

(ii) the plan is revised by the insurer or health organization, with or without the commissioner's recommendation.

(10) "RBC report" means the report required in Section 31A-17-602.

Amended by Chapter 116, 2001 General Session

31A-17-602. RBC reports -- RBC of life and accident and health insurers -- RBC of property and casualty insurers.

(1) Every domestic life or accident and health insurer, every domestic property and casualty insurer, and every domestic health organization shall:

(a) on or before March 1, prepare and submit to the commissioner a report of its RBC levels as of the end of the calendar year just ended, in a form and containing the information as is required by the RBC instructions;

(b) file its RBC report with the insurance commissioner in any state in which the insurer or health organization is authorized to do business, if the insurance commissioner of that state notifies the insurer or health organization of its request in writing, in which case the insurer or health organization may file its RBC report not later than the later of:

(i) 15 days from the receipt of notice to file its RBC report with that state; or

(ii) March 1; and

(c) file the documents described in Subsections (1)(a) and (b) with the National Association of Insurance Commissioners in accordance with RBC instructions.

(2) A life and accident and health insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take into account and may adjust for the covariance between:

(a) the risk with respect to the insurer's assets;

(b) the risk of adverse insurance experience with respect to the insurer's liabilities and obligations;

(c) the interest rate risk with respect to the insurer's business; and

(d) all other business risks and other relevant risks as set forth in the RBC instructions.

(3) A property and casualty insurer's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account and may adjust for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and the other relevant risks as set forth in the RBC instructions.

(4) A health organization's RBC shall be determined in accordance with the formula set forth in the RBC instructions. The formula shall take the following into account and may adjust for the covariance between:

(a) asset risk;

(b) credit risk;

(c) underwriting risk; and

(d) all other business risks and such other relevant risks as are set forth in the RBC instructions.

(5) (a) If a domestic insurer files an RBC report that the commissioner determines is inaccurate, the commissioner shall adjust the RBC report to correct the inaccuracy and shall notify the insurer of the adjustment.

(b) The notice under Subsection (5)(a) shall contain a statement of the reason for the adjustment.

(6) The commissioner may make rules to assist in applying the provisions of this part to health organizations.

Amended by Chapter 116, 2001 General Session

31A-17-603. Company action level event.

(1) "Company action level event" means any of the following events:

(a) the filing of an RBC report by an insurer or health organization that indicates that:

(i) the insurer's or health organization's total adjusted capital is greater than or equal to its regulatory action level RBC but less than its company action level RBC;

(ii) if a life or accident and health insurer, the insurer has:

(A) total adjusted capital that is greater than or equal to its company action level RBC but less than the product of its authorized control level RBC and 3.0; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the life or fraternal RBC instructions; or

(iii) if a property and casualty insurer, the insurer has:

(A) total adjusted capital that is greater than or equal to its company action level RBC, but less than the product of its authorized control level RBC and 3.0; and

(B) triggers the trend test determined in accordance with the trend test calculation included in the property and casualty RBC instructions;

(b) the notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates an event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607; or

(c) if, pursuant to Section 31A-17-607, an insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(2) (a) In the event of a company action level event, the insurer or health organization shall prepare and submit to the commissioner an RBC plan that shall:

(i) identify the conditions that contribute to the company action level event;

(ii) contain proposals of corrective actions that the insurer or health organization intends to take and that are expected to result in the elimination of the company action level event;

(iii) provide projections of the insurer's or health organization's financial results in the current year and at least the four succeeding years, both in the absence of proposed corrective actions and giving effect to the proposed corrective actions, including projections of:

(A) statutory operating income;

(B) net income;

(C) capital;

(D) surplus; and

(E) RBC levels;

(iv) identify the key assumptions impacting the insurer's or health organization's projections and the sensitivity of the projections to the assumptions; and

(v) identify the quality of, and problems associated with, the insurer's or health organization's business, including its assets, anticipated business growth and associated surplus strain, extraordinary exposure to risk, mix of business and use of reinsurance, if any, in each case.

(b) For purposes of Subsection (2)(a)(iii), the projections for both new and renewal business may include separate projections for each major line of business and separately identify each significant income, expense, and benefit component.

(3) The RBC plan shall be submitted:

(a) within 45 days of the company action level event; or

(b) if the insurer or health organization challenges an adjusted RBC report pursuant to Section 31A-17-607, within 45 days after notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(4) (a) Within 60 days after the submission by an insurer or health organization of an RBC plan to the commissioner, the commissioner shall notify the insurer or health organization whether the RBC plan:

(i) shall be implemented; or

(ii) is unsatisfactory.

(b) If the commissioner determines the RBC plan is unsatisfactory, the notification to the insurer or health organization shall set forth the reasons for the determination, and may propose revisions that will render the RBC plan satisfactory. Upon notification from the commissioner, the insurer or health organization shall:

(i) prepare a revised RBC plan that incorporates any revision proposed by the commissioner; and

(ii) submit the revised RBC plan to the commissioner:

(A) within 45 days after the notification from the commissioner; or

(B) if the insurer challenges the notification from the commissioner under Section 31A-17-607, within 45 days after a notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(5) In the event of a notification by the commissioner to an insurer or health organization that the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory, the commissioner may specify in the notification that the notification constitutes a regulatory action level event subject to the insurer's or health organization's right to a hearing under Section 31A-17-607.

(6) Every domestic insurer or health organization that files an RBC plan or revised RBC plan with the commissioner shall file a copy of the RBC plan or revised RBC plan with the insurance commissioner in any state in which the insurer or health organization is authorized to do business if:

(a) the state has an RBC provision substantially similar to Subsection 31A-17-608(1); and

(b) the insurance commissioner of that state notifies the insurer or health organization of its request for the filing in writing, in which case the insurer or health organization shall file a copy of the RBC plan or revised RBC plan in that state no later than the later of:

(i) 15 days after the receipt of notice to file a copy of its RBC plan or revised

RBC plan with that state; or

(ii) the date on which the RBC plan or revised RBC plan is filed under Subsections (3) and (4).

Amended by Chapter 319, 2013 General Session

31A-17-604. Regulatory action level event.

(1) "Regulatory action level event" means with respect to any insurer or health organization, any of the following events:

(a) the filing of an RBC report by the insurer or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its authorized control level RBC but less than its regulatory action level RBC;

(b) the notification by the commissioner to an insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607;

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge;

(d) the failure of the insurer or health organization to file an RBC report by March 1, unless the insurer or health organization has:

(i) provided an explanation for the failure that is satisfactory to the commissioner; and

(ii) cured the failure within 10 days after March 1;

(e) the failure of the insurer or health organization to submit an RBC plan to the commissioner within the time period set forth in Subsection 31A-17-603(3);

(f) notification by the commissioner to the insurer or health organization that:

(i) the RBC plan or revised RBC plan submitted by the insurer or health organization is unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer or health organization, provided the insurer has not challenged the determination under Section 31A-17-607;

(g) if, pursuant to Section 31A-17-607, the insurer or health organization challenges a determination by the commissioner under Subsection (1)(f), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the challenge; or

(h) notification by the commissioner to the insurer or health organization that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan, but only if:

(i) the failure has a substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event in accordance with its RBC plan or revised RBC plan; and

(ii) the commissioner has so stated in the notification, provided the insurer or health organization has not challenged the determination under Section 31A-17-607; or

(iii) if, pursuant to Section 31A-17-607, the insurer or health organization

challenges a determination by the commissioner under Subsection (1)(h), the notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the challenge.

(2) In the event of a regulatory action level event the commissioner shall:

(a) require the insurer or health organization to prepare and submit an RBC plan or, if applicable, a revised RBC plan;

(b) perform any examination or analysis the commissioner considers necessary of the assets, liabilities, and operations of the insurer or health organization, including a review of its RBC plan or revised RBC plan; and

(c) subsequent to the examination or analysis, issue a corrective order specifying the corrective action the commissioner determines is required.

(3) In determining a corrective action, the commissioner may take into account such factors the commissioner considers relevant with respect to the insurer or health organization based upon the commissioner's examination or analysis of the assets, liabilities, and operations of the insurer or health organization, including the results of any sensitivity tests undertaken pursuant to the RBC instructions. The RBC plan or revised RBC plan shall be submitted:

(a) within 45 days after the occurrence of the regulatory action level event;

(b) if the insurer or health organization challenges an adjusted RBC report pursuant to Section 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45 days after the notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge; or

(c) if the insurer or health organization challenges a revised RBC plan pursuant to Section 31A-17-607 and the commissioner determines the challenge is not frivolous, within 45 days after the notification to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

Amended by Chapter 116, 2001 General Session

31A-17-605. Authorized control level event.

(1) "Authorized control level event" means any of the following events:

(a) the filing of an RBC report by the insurer or health organization that indicates that the insurer's or health organization's total adjusted capital is greater than or equal to its mandatory control level RBC but less than its authorized control level RBC;

(b) the notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607;

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge;

(d) the failure of the insurer or health organization to respond, in a manner satisfactory to the commissioner, to a corrective order, provided the insurer or health organization has not challenged the corrective order under Section 31A-17-607; or

(e) if the insurer or health organization has challenged a corrective order under Section 31A-17-607 and the commissioner after a hearing rejects the challenge or modifies the corrective order, the failure of the insurer or health organization to respond, in a manner satisfactory to the commissioner, to the corrective order subsequent to rejection or modification by the commissioner.

(2) (a) In the event of an authorized control level event with respect to an insurer or health organization, the commissioner shall:

(i) take any action required under Section 31A-17-604 regarding an insurer or health organization with respect to which a regulatory action level event has occurred; or

(ii) take any action as is necessary to cause the insurer or health organization to be placed under regulatory control under Chapter 27, Part 5, Administrative Actions, if the commissioner considers it to be in the best interests of:

(A) the policyholders or members;

(B) creditors of the insurer or health organization; and

(C) the public.

(b) If the commissioner takes an action described in Subsection (2)(a), the authorized control level event is sufficient grounds for the commissioner to take action under Chapter 27, Part 5, Administrative Actions, and the commissioner shall have the rights, powers, and duties with respect to the insurer or health organization set forth in Chapter 27, Part 5, Administrative Actions.

(c) If the commissioner takes an action under Subsection (2)(a) pursuant to an adjusted RBC report, the insurer or health organization is entitled to the protections afforded to an insurer or health organization under Section 31A-27-504 pertaining to an action by the commissioner.

Amended by Chapter 309, 2007 General Session

31A-17-606. Mandatory control level event.

(1) "Mandatory control level event" means any of the following events:

(a) the filing of an RBC report that indicates that the insurer's or health organization's total adjusted capital is less than its mandatory control level RBC;

(b) notification by the commissioner to the insurer or health organization of an adjusted RBC report that indicates the event in Subsection (1)(a), provided the insurer or health organization does not challenge the adjusted RBC report under Section 31A-17-607; or

(c) if, pursuant to Section 31A-17-607, the insurer or health organization challenges an adjusted RBC report that indicates the event in Subsection (1)(a), notification by the commissioner to the insurer or health organization that after a hearing the commissioner rejects the insurer's or health organization's challenge.

(2) (a) In the event of a mandatory control level event with respect to an insurer or health organization, the commissioner shall take any actions necessary to place the insurer under regulatory control under Chapter 27, Part 5, Administrative Actions.

(b) The mandatory control level event is sufficient grounds for the commissioner to take action under Chapter 27, Part 5, Administrative Actions, and the commissioner shall have the rights, powers, and duties with respect to the insurer or health

organization as are set forth in Chapter 27, Part 5, Administrative Actions.

(c) If the commissioner takes an action pursuant to an adjusted RBC report, the insurer or health organization is entitled to the protections of Section 31A-27-504 pertaining to summary proceedings.

(d) Notwithstanding the other provisions of Subsection (2), the commissioner may forego action for up to 90 days after the mandatory control level event if the commissioner finds there is a reasonable expectation that the mandatory control level event may be eliminated within the 90-day period.

Amended by Chapter 309, 2007 General Session

31A-17-607. Hearings.

(1) (a) Following receipt of a notice described in Subsection (2), the insurer or health organization shall have the right to a confidential departmental hearing at which the insurer or health organization may challenge a determination or action by the commissioner.

(b) The insurer or health organization shall notify the commissioner of its request for a hearing within five days after the notification by the commissioner under Subsection (2).

(c) Upon receipt of the insurer's or health organization's request for a hearing, the commissioner shall set a date for the hearing, which date shall be no less than 10 nor more than 30 days after the date of the insurer's or health organization's request.

(2) An insurer or health organization has the right to a hearing under Subsection (1) after:

(a) notification to an insurer or health organization by the commissioner of an adjusted RBC report;

(b) notification to an insurer or health organization by the commissioner that:

(i) the insurer's or health organization's RBC plan or revised RBC plan is unsatisfactory; and

(ii) the notification constitutes a regulatory action level event with respect to the insurer or health organization;

(c) notification to any insurer or health organization by the commissioner that the insurer or health organization has failed to adhere to its RBC plan or revised RBC plan and that the failure has substantial adverse effect on the ability of the insurer or health organization to eliminate the company action level event with respect to the insurer or health organization in accordance with its RBC plan or revised RBC plan; or

(d) notification to an insurer or health organization by the commissioner of a corrective order with respect to the insurer or health organization.

Amended by Chapter 290, 2014 General Session
Amended by Chapter 300, 2014 General Session

31A-17-608. Confidentiality -- Prohibition on announcements -- Prohibition on use in ratemaking.

(1) (a) The commissioner shall keep confidential to the extent that information in a report or plan is not required to be included in a publicly available annual statement

schedule, any detail in an RBC report or RBC plan including the results or report of any examination or analysis of an insurer or health organization performed pursuant to this part, that is filed by a domestic or foreign insurer or health organization with the commissioner or any corrective order issued by the commissioner pursuant to examination or analysis.

(b) Information kept confidential under Subsection (1)(a) may not be made public or be subject to subpoena, other than by the commissioner and then only for the purpose of enforcement actions taken by the commissioner pursuant to this part or any other provision of the insurance laws of this state.

(2) (a) Except as otherwise required under this part, any insurer or health organization, producer, or other person engaged in any manner in the insurance business may not publish, disseminate, circulate or place before the public, or cause, directly or indirectly, the publishing, disseminating, circulating or placing before the public including, in a newspaper, magazine, other publication, a notice, circular, pamphlet, letter, or poster, or over any radio or television station, an advertisement, announcement, or statement containing an assertion, representation, or statement with regard to the RBC levels of any insurer or health organization, or of any component derived in the calculation.

(b) If any materially false statement with respect to the comparison regarding an insurer's or health organization's total adjusted capital to its RBC levels, or an inappropriate comparison of any other amount to the insurer's or health organization's RBC levels is published in any written publication and the insurer or health organization is able to demonstrate to the commissioner with substantial proof the falsity of the statement or the inappropriateness, the insurer or health organization may publish an announcement in a written publication if the sole purpose of the announcement is to rebut the materially false statement or inappropriate comparison.

(3) The commissioner may not use an RBC instruction, report, plan, or revised plan:

(a) for ratemaking;

(b) as evidence in any rate proceeding; or

(c) to calculate or derive any element of an appropriate premium level or rate of return for any line of insurance or coverage that an insurer or health organization or any affiliate is authorized to write or cover.

Amended by Chapter 298, 2003 General Session

31A-17-609. Alternate adjusted capital.

(1) Except as provided in Section 31A-17-602, an insurer or health organization licensed under Chapters 5, 7, 8, 9, and 14 shall maintain total adjusted capital as defined in Section 31A-1-301 in an amount equal to the greater of:

(a) 175% of the minimum required capital, or of the minimum permanent surplus in the case of nonassessable mutuals, required by Section 31A-5-211, 31A-7-201, 31A-8-209, 31A-9-209, or 31A-14-205; or

(b) the net total of:

(i) 10% of net insurance premiums earned during the year; plus

(ii) 5% of the admitted value of common stocks and real estate; plus

(iii) 2% of the admitted value of all other invested assets, exclusive of cash deposits, short-term investments, policy loans, and premium notes; less

(iv) the amount of any asset valuation reserve being maintained by the insurer or health organization, but not to exceed the sum of Subsections (1)(b)(ii) and (iii).

(2) As used in Subsection (1)(b), "premiums earned" means premiums and other consideration earned for insurance in the 12-month period ending on the date the calculation is made.

(3) The commissioner may consider an insurer or health organization to be financially hazardous under Subsection 31A-27a-207(1)(i), if the insurer or health organization does not have qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's liabilities and the total adjusted capital required by Subsection (1).

(4) The commissioner shall consider an insurer or health organization to be financially hazardous under Subsection 31A-27a-207(1)(i) if the insurer or health organization does not have qualified assets in an aggregate value exceeding the sum of the insurer's or health organization's liabilities and 70% of the total adjusted capital required by Subsection (1).

Amended by Chapter 309, 2007 General Session

31A-17-610. Foreign insurers or health organizations.

(1) (a) Any foreign insurer or health organization shall, upon the written request of the commissioner, submit to the commissioner an RBC report as of the end of the most recent calendar year by the later of:

(i) the date an RBC report would be required to be filed by a domestic insurer or health organization under this part; or

(ii) 15 days after the request is received by the foreign insurer or health organization.

(b) Any foreign insurer or health organization shall, at the written request of the commissioner, promptly submit to the commissioner a copy of any RBC plan that is filed with the insurance commissioner of any other state.

(2) (a) The commissioner may require a foreign insurer or health organization to file an RBC plan with the commissioner if:

(i) there is a company action level event, regulatory action level event, or authorized control level event with respect to the foreign insurer or health organization as determined under:

(A) the RBC statute applicable in the state of domicile of the insurer or health organization; or

(B) if no RBC statute is in force in that state, under this part; and

(ii) the insurance commissioner of the state of domicile of the foreign insurer or health organization fails to require the foreign insurer or health organization to file an RBC plan in the manner specified under:

(A) that state's RBC statute; or

(B) if no RBC statute is in force in that state, under Section 31A-17-603.

(b) If the commissioner requires a foreign insurer or health organization to file an RBC plan, the failure of the foreign insurer or health organization to file the RBC plan

with the commissioner is grounds to order the insurer or health organization to cease and desist from writing new insurance business in this state.

(3) The commissioner may make application to the Third District Court for Salt Lake County permitted under Section 31A-27a-901 with respect to the liquidation of property of a foreign insurer or health organization found in this state if:

(a) a mandatory control level event occurs with respect to any foreign insurer or health organization; and

(b) no domiciliary receiver has been appointed with respect to the foreign insurer or health organization under the rehabilitation and liquidation statute applicable in the state of domicile of the foreign insurer or health organization.

Amended by Chapter 309, 2007 General Session

31A-17-611. Immunity.

There may be no liability on the part of, and no cause of action may arise against, the commissioner or the insurance department or its employees or agents for any action taken by them in the performance of their powers and duties under this part.

Enacted by Chapter 9, 1996 Special Session 2

31A-17-612. Severability clause.

If any provision of this part, or the application of the part to any person or circumstance, is held invalid, the determination may not affect the provisions or applications of this part that can be given effect without the invalid provision or application, and to that end the provisions of this part are severable.

Enacted by Chapter 9, 1996 Special Session 2

31A-17-613. Effective date of notice.

A notice by the commissioner to an insurer or health organization that may result in regulatory action under this chapter is effective the sooner of:

(1) the date the insurer or health organization receives the notice; or

(2) three days after mailing the notice.

Amended by Chapter 116, 2001 General Session